STATE OF WISCONSIN

DEPARTMENT OF HEALTH SERVICES

WISCONSIN SENIORCARE

A PHARMACEUTICAL BENEFIT FOR LOW-INCOME WISCONSIN SENIORS

1115 DEMONSTRATION PROJECT RENEWAL

FINAL APPLICATION

August 31, 2012

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I. INTRODUCTION

The State of Wisconsin Department of Health Services (DHS) requests a three-year renewal to its Section 1115 Demonstration Project for the SeniorCare prescription drug assistance program. The current waiver is scheduled to expire on December 31, 2012. The State requests that the waiver be renewed for an additional three-year period, from January 1, 2013 to December 31, 2015.

Background

On July 1, 2002, The State of Wisconsin received the necessary waiver approvals from the Centers for Medicare & Medicaid Services (CMS) to operate a portion of SeniorCare, a prescription drug benefit for seniors, as a five-year demonstration project. Through its partnership with the federal government, the SeniorCare waiver extends Medicaid eligibility through Title XIX to cover prescription drugs as a necessary primary health care benefit.

The target population for services under this demonstration project is seniors 65 years of age or older with income at or below 200% of the federal poverty level (FPL), which was $22,340 for an individual and $30,260 for a two-person family in 2012.

Since its implementation in September 1, 2002, the SeniorCare waiver program has successfully delivered a comprehensive outpatient drug benefit to more than 152,000 seniors in the state. In 2011, the average age of a SeniorCare waiver program member was 80 years old, with 32% of members aged 85 years and older. Also in 2011, 75% of waiver members were women.

Advantages of SeniorCare

Simple Application and Enrollment Process

The SeniorCare application consists of a simple, one-page application form, which must be mailed to the SeniorCare central application processing center with a $30 enrollment fee. SeniorCare requires no asset test, and unlike the enrollment policies of Medicare Part D, seniors may enroll at any time without penalty. Once approved, seniors are enrolled for a 12-month benefit period. Toward the end of the 12-month period, members are reminded that they must re-apply for enrollment in the program.

Open Formulary and Broad Network of Providers

SeniorCare is a comprehensive drug benefit that is easy for seniors to access. SeniorCare has an open formulary, nearly identical to that of Wisconsin Medicaid, and covers all legend drugs with a federal rebate agreement and over-the-counter insulin. In addition, SeniorCare provides access to a robust network of pharmacies. More than 1,300 pharmacies in-state and another 100 out-of-state are certified as SeniorCare providers.

Affordable and Predictable Cost-Sharing for Members

SeniorCare has predictable and affordable cost sharing requirements with no significant gaps in coverage. All SeniorCare members pay an annual $30 enrollment fee and incur co-pays of just $5 for generic drugs and $15 for brand name drugs. Individuals or couples with income at or below 160% FPL have no other out-of-pocket costs. Those whose incomes fall between 160% and 200% FPL pay the first $500 in prescription drug costs at the SeniorCare rate.

Program Cost-Effectiveness

SeniorCare is a financially efficient program for all payers. In CY 2011, total drug expenditures billed to SeniorCare of nearly $114 million were reduced to just over $43 million, which was paid for by state and federal tax dollars, manufacturer rebates and member cost sharing.

Continued Cost-Effectiveness with SeniorCare Waiver Renewal (Budget Neutrality)

The Department projects that the waiver renewal will continue to reduce Medicaid expenditures for the aged population, 65 and older, from what would have been expended without the waiver, by providing primary care benefits for pharmacy coverage.

As in the original waiver period, budget neutrality will continue to be achieved by reducing the rate of increase in the use of non-pharmacy related services provided to this population including, hospital, nursing facility and other non-pharmacy medical services. These savings will offset the costs of continuing the SeniorCare pharmacy benefit. Reductions in expenditures will also be realized by the Medicare Program through reduced hospitalizations for this population group.

The projections also take into account the availability of Medicare Part D beginning in SFY 07 and through the waiver renewal period.

The SeniorCare waiver has achieved budget neutrality throughout the original waiver period as well as all renewal periods. Analysis predicts that the SeniorCare program savings were approximately $151 million for each year between CY 2010 and CY 2012.

Savings are the direct result of reduced Medicaid payments for hospital and nursing home care because seniors with SeniorCare prescription drug coverage are diverted from spending down income and assets to Medicaid eligibility levels. By keeping seniors healthier longer, SeniorCare reduces Medicare expenditures as well.

Excellent Value for Members

SeniorCare also provides exceptional value to its members. In SFY 2011, SeniorCare reduced drug costs for Wisconsin seniors by approximately $114 million.

Keeps Seniors Healthier, Longer, and Reduces Medicaid Costs

SeniorCare benefits seniors by keeping them healthy, through access to medications that are instrumental in the control and prevention of adverse health conditions. Keeping Wisconsin's seniors healthy prevents Medicaid eligibility and related costs.

OVERVIEW

A. Prescription Drugs and the Elderly

As health care costs continue to rise for all Americans, access to drugs for this population, a basic primary care benefit, is increasingly important. The lack of access to essential medications for the chronically ill and those with acute diseases result in an increase in hospital and nursing home costs. Use of prescription drugs not only improves the quality of primary care services, but is also cost-effective when including the cost of hospitalization or long term care. Studies have estimated that every dollar spent on pharmaceutical coverage is associated with a significant reduction in hospital expenditures. These savings relate not only to the preventive nature of some pharmaceuticals, but also to the fact that inadequate coverage of this primary care benefit causes millions of low-income elderly to reduce their use of clinically essential medications. The improper use of essential medications due to income constraints increases hospital and nursing home admissions, increasing health care costs in the aggregate.

B. Current Elderly and Disabled Wisconsin Medicaid Eligibility

1. Supplemental Security Income (SSI)

Wisconsin provides Medicaid coverage to all persons who receive federally funded cash assistance under the Supplemental Security Income (SSI) program. Wisconsin is not a section 209(b) state and, thus, does not impose more restrictive eligibility standards than SSI.

Within the population of SSI-eligible elderly and disabled persons, the federally mandated coverage group is persons who qualify for and receive the federal SSI payment. Wisconsin has chosen to cover the additional optional groups of persons who receive a state-only supplemental payment, as well as persons who are eligible for the federal SSI payment, but choose not to receive it.

Wisconsin meets federal requirements with regard to a number of groups of persons formerly eligible for SSI. Wisconsin covers certain disabled persons who have returned to work and lost SSI eligibility as a result of employment earnings, but still

have the condition that rendered them disabled (and meet all non-disability criteria for SSI except income). Also covered are persons once eligible for both SSI and Social Security payments who lost their SSI because of certain cost of living adjustments to their Social Security. Similar Medicaid continuations are provided for certain other persons who become ineligible for SSI due to eligibility for, or increases in, Social Security or veterans' benefits.

Wisconsin also maintains Medicaid coverage for certain SSI-related groups who received benefits in 1973, including persons who care for disabled individuals.

2. Medically Needy

Wisconsin also offers Medicaid coverage to medically needy elderly and disabled persons. By federal law, the associated income standards may not exceed 133.3 percent of the maximum AFDC payment that would have been paid to a family as of July 16, 1996. Wisconsin exercises the federal option to apply the higher two-person standard to single individuals. Further, Wisconsin has opted to provide nursing home care as part of its medically needy program benefit package.

Medical costs are covered under Wisconsin's medically needy Medicaid program when the person (or family) is eligible for Medicaid in all ways, except income level, and incurs medical expenses equivalent to the income over the medically needy limit.

3. Institutional and Other Long-Term Care

Wisconsin provides Medicaid coverage to nursing home residents and persons participating in community-based long-term care programs under a special optional institutional income rule. This rule permits persons who are not categorically eligible for SSI and who have income between 100 and 300 percent of the monthly federal SSI payment amount, to be eligible for Medicaid without spending down to the medically needy income limit. Wisconsin has opted to provide coverage at the maximum of 300 percent of the monthly SSI payment level.

4. Medicaid Purchase Plan

In March, 2000, Wisconsin implemented a new option provided under federal Medicaid law, extending Medicaid coverage to certain working, disabled adults. The program is intended to remove financial disincentives to work and generally covers disabled individuals with income greater than 250% FPL. Disability and family income are determined in accordance with SSI rules and there is a $15,000 asset limit. Program members must engage in gainful employment, or participate in a program certified to

provide health and employment services aimed at helping the individual achieve employment goals.

5. Low-Income Medicare Beneficiaries

Wisconsin provides limited Medicaid coverage to the following groups of low-income Medicare beneficiaries:

- Qualified Medicare Beneficiaries (QMB): These are persons entitled to Medicare hospital insurance benefits (i.e., Medicare Part A) whose income does not exceed 100% FPL and whose resources do not exceed twice the Supplemental Security Income (SSI) resource limit. For such persons, Medicaid reimburses any required Medicare premium, coinsurance and deductibles for both Parts A and B. Cost sharing amounts are paid up to the maximum amount Medicaid would reimburse for the service rendered.

- Specified Low-Income Medicare Beneficiaries (SLMB); Medicaid pays the full Part B premium for persons who otherwise meet the QMB requirements, but have income between 100 and 120% FPL.

- Qualifying Individuals I (QI I): Medicaid pays the full Part B premium for persons who are not eligible for full-benefit Medicaid, but who otherwise meet the QMB /SLMB requirements, but have income greater than 120% FPL, but not exceeding 135% FPL.

- Qualified Disabled and Working Individuals (QDWI): These are persons who formerly received social security disability benefits and Medicare, have lost eligibility for both programs, but are permitted under Medicare law to continue to receive Medicare in return for payment of the Part A premium. Wisconsin has chosen to pay the entire Part A premium for persons in this category who are under age 65, with income at or below 200% FPL and with assets up to twice the SSI resource limits (and who are not otherwise Medicaid eligible).

C. Overview of SeniorCare; Demonstration Project Renewal Program

In response to the critical need for prescription drug coverage for the elderly, the State of Wisconsin, as part of 2001 Wisconsin Act 16, established a prescription drug assistance program titled SeniorCare. SeniorCare statutes require the Department of Health Services submit to the U.S. Department of Health and Human Services a request that SeniorCare be covered under a Medicaid 1115 Demonstration Project, which was granted in 2002.

Under the terms of the waiver, SeniorCare has and will continue to comply with federal and state laws and regulations (except those for which a specific waiver is requested) for Medicaid eligibility, benefits, and administration, including application processing, claims processing, federal reporting, and safeguards for fraud and abuse.

This waiver serves seniors with incomes at or below 200% FPL. Since implementation on September 1, 2002, the SeniorCare waiver has successfully delivered a comprehensive outpatient drug benefit to over 152,000 seniors in the state. As of December, 2011, 89,000 seniors were enrolled in SeniorCare. More than 58,000 of these seniors were enrolled in the waiver portion of the program (at or below 200% FPL).

The successful and popular SeniorCare program has received strong support from the Wisconsin Legislature, which fully funded SeniorCare in the most recent biennium, appropriating $29.2 million in general purpose revenue (GPR) in SFY 2012 and $30.9 million GPR in SFY 2012. These state funds are an important funding stream, approximately 25 percent, of the SeniorCare program.

The State of Wisconsin Department of Health, the agency that administers the state's Medicaid program, also administers SeniorCare. Through a Section 1115 Research and Demonstration Project renewal, Wisconsin seeks to continue Medicaid federal matching funds for individuals who qualify for SeniorCare pharmacy benefits.

By extending access to prescription drugs for the elderly, Wisconsin will continue to provide a needed health care benefit to low-income seniors. Continuing to provide pharmacy benefits through SeniorCare will provide the following benefits, even with the availability of Part D:

- Help to preserve the health of the senior population by providing financial support for costly but essential drugs, thereby providing more affordable and comprehensive primary health care services.
- Improve the quality of life of Wisconsin's seniors, thus allowing them to remain in less costly home and community settings while avoiding expensive acute or long-term care services resulting from a lack of access to necessary drugs.
- Reduce the rate at which seniors spend down to Medicaid eligibility and become entitled to all benefits available under the Medicaid program.
- Save the federal government money by improving the health of seniors, resulting in savings to the Medicare program.
- Provide an outpatient pharmacy benefit that is an excellent value to the federal government, by offsetting federal expenditures with a substantial state financial commitment and substantial (approximately 55% of expenditures) manufacturer rebates.

Under the program, Wisconsin-residents who are ages 65 years of age and older, not currently eligible for Medicaid benefits, and whose income does not exceed 200% FPL, are eligible for coverage of legend drugs and over-the-counter insulin as currently provided under the Wisconsin Medicaid State Plan. Those seniors with prescription drug coverage under other plans are also eligible to enroll, with SeniorCare covering eligible costs not covered under other plans. There is no asset test.

Enrollees pay an annual $30 enrollment fee. Individuals with income at or below 160% FPL are responsible for a copayment of $15 for a brand name drug and $5 for a generic drug, for each prescription drug. Individuals with an income above 160% FPL but at or below 200% FPL are also responsible for the first $500 of prescription drug costs each year.

The simple, one-page application form requests the applicant's name, age, social security number, income, residence, spouse's name and other limited information needed to determine the person's eligibility. The form is easy to read and complete. Seniors submit applications by mail to a central processing center administered by the Department.

Customer notices inform seniors about their eligibility, whether they have an annual payment, and other information regarding their participation in the program. Upon enrollment into SeniorCare, waiver program members receive an identification card, distinct from the normal Medicaid card, which enrollees use when purchasing prescription drugs. Enrollees are certified to begin participation in the program on the first day of the month following the month in which all eligibility criteria are met. Once determined eligible for the waiver program, an individual may remain eligible for 12 months from the date of initial enrollment, regardless of changes in income.

SeniorCare uses the state Medicaid program's Point-of-Sale (POS) system for claims processing. The POS system has mechanisms in place for drug pricing, calculation of copayments and deductibles, coordination of benefits, STAT prior authorization, prospective and retrospective Drug Utilization Review (DUR), and other cost containment processes. The system enables Medicaid-certified providers to submit real-time claims electronically for prescription drugs and to receive an electronic response indicating payment or denial within seconds of submitting the claim. The system also verifies member eligibility, including other health insurance coverage, and tracks members' deductibles and copayments, again with the information available to pharmacists in real-time. As a result, seniors filling their prescriptions may receive up-to-date information about their prescription costs.

Similar to Medicaid, SeniorCare must coordinate eligibility across programs and coordinate with benefits covered by other insurers. Many seniors who are eligible for

SeniorCare are also eligible for programs such as Food Share or other economic support programs. A SeniorCare customer service hotline, which began operations in July 2002, responds to questions about eligibility, applications and program benefits. SeniorCare application processing staff are trained to answer questions and provide referrals for Seniors seeking information about SeniorCare or other programs.

Existing systems that support the Medicaid program are used for automated support for eligibility and enrollment functions. The state leverages existing system capacity to meet the program needs in the most efficient way.

II. DEMONSTRATION PROJECT RENEWAL PROGRAM DESIGN

Wisconsin will continue the current SeniorCare program design through the demonstration project renewal, as described below.

A. Eligibility Requirements

State Medicaid programs may have two types of eligibility categories: categorically needy and medically needy. Both categories are established under the Social Security Act. Certain groups, such as pregnant women or the elderly, are considered categorically eligible if they also meet income criteria based on the FPL, Medically needy eligibles are those that would be categorically needy except for their slightly higher income, but who cannot afford to pay their medical bills. To be eligible for prescription drug services under this 1115 Research and Demonstration Project, individuals must:

1. Be a Wisconsin resident;
2. Be a citizen or have qualifying immigrant status;
3. Not be a recipient of Medicaid, other than as a low-income Medicare beneficiary (QMB, SLMB , QI-1 or QDWI);
4. Be age 65 or older; and
5. Pay the applicable annual enrollment fee of $30 per person.

Individuals must also have a household income at or below 200% FPL. Individuals with a household income above 200% FPL receive program benefits after they have met program requirements for deductible and spenddown, if required. Income is calculated as follows:

- A gross income test is used, except in cases of self-employment income. The standard elderly, blind and disabled (EBD) Medicaid deductions or other deductions are not applied.

- In cases of self-employment income, current Medicaid policy for elderly, blind and disabled programs is followed. Therefore, deductions for business expenses, losses and depreciation are permitted for persons with self-employment income.

- Income is determined on a prospective basis, annually.

- A fiscal test group that is consistent with current Medicaid policy for the elderly, blind and disabled Medicaid program is used. Thus, the income of the individual is used for persons not living with a spouse, and the income of the couple is used for married persons who reside with their spouse. These income amounts are compared to the FPL for a group size of one if counting only the income of the individual and group size of two if counting the income of the applicant and his or her spouse.

- There is no asset test related to eligibility for the waiver program.

B. Application Process for Pharmacy Waiver Benefits

The application process for eligible seniors in this 1115 Research and Demonstration Project is comprised of the following components:

- Completion of the simple, short application.

- Applications are processed by a central unit administered by the Department.

- Applications are accepted by mail and online.

- Near the end of an individual's year of eligibility, the Department notifies the member of the need for an annual re-determination of his or her eligibility. The Department provides the individual with a pre-printed renewal form containing some of the information provided in the previous year. To continue coverage, the form must be filed in a timely manner and receive approval. The individual must also pay the annual enrollment fee.

- Upon enrollment, SeniorCare waiver program members receive an identification card distinct from the current Medicaid card. Members must present their identification card to the pharmacy or pharmacist when purchasing prescription drugs.

- The enrollment process focuses primarily on eligibility for the SeniorCare Medicaid waiver program. In addition, seniors are advised to complete a full Medicaid application if they are applying for benefits other than prescription drugs.

C. Enrollment Periods

Enrollment periods for eligible members are as follows:

- Once determined eligible for the SeniorCare waiver program, an individual may remain eligible for 12 months from the date of initial enrollment, regardless of changes in income. However, if a person permanently leaves the State of Wisconsin or becomes deceased, the person is no longer eligible for the waiver program.
- Members may reapply if their income decreases. For example, if a person with an income determination of 165% FPL subsequently loses a part-time job resulting in income below 160% FPL, the individual may reapply. In this situation, the person would no longer be required to pay the first $500 in prescription drug costs, but would need to pay a new $30 enrollment fee to establish a new 12-month benefit period.
- A person is certified to begin participation in the program on the first day of the month following the month in which all eligibility criteria are met.
- Eligibility for benefits is prospective only. There is no retroactive eligibility.

D. Coordination of Benefits

The waiver program pharmacy benefit extends coverage only to legend (prescription) drugs and to over-the-counter insulin; these are drugs that are currently covered by the Wisconsin Medicaid State Plan. Coordination of benefits is applied in a manner similar to the Medicaid Program. The SeniorCare Program uses a combination of automated, pre-payment cost avoidance with the Point-of-Sale (POS) system and, where necessary, will bill liable third parties after the payment is made.

If a person is eligible to receive Medication Therapy Management (MTM) services through Medicare, the pharmacist is required to submit claims to Medicare. SeniorCare is the payer of last resort for these services.

E. Cost Sharing

Program members are required to comply with cost sharing provisions that vary by income level. The following describes the cost sharing features in more detail.

1. Annual Enrollment Fees

All members are required to pay an annual enrollment fee of $30. Upon determining eligibility, all enrollees will receive a letter notifying them of their eligibility and cost-sharing requirements. All enrollees receive the

option to decline participation if the person notifies the Department within the 30-day processing period, or 10 days from the date the Department sends the letter, whichever is later. If a person declines participation within this time period, the Department refunds the enrollment fee paid for that benefit period. If a person has paid the annual enrollment fee with his or her application and is determined ineligible for the program, the Department refunds the paid enrollment fee.

2. Annual Costs for Certain Members

Certain members pay the first $500 in prescription drug costs each enrollment period.

- Members with income between 160% FPL and 200% FPL are responsible for the first $500 of prescription drug costs per year. The first $500 will be paid by the member at the SeniorCare rate.
- If members choose MTM services at dispensing and their income is between 160% FPL and 200% FPL, they are responsible for paying Medicaid rates for the MTM services while in the $500 deductible period. Member payments toward MTM services will count toward the member's deductible.
- Members with income at or below 160% FPL are not required to pay the first $500 of prescription drug costs.

3. Copayments

For members with income above 160% FPL who have met the $500 annual deductible and for members with income at or below 160% FPL, a copayment is required for each prescription drug for the remainder of that 12-month period. The following copayments apply:

- $15 copayment per prescription for brand name drugs.
- $5 copayment per prescription for generic drugs.
- There is no copayment for Medication Therapy Management (MTM) services.

F. Coordination with Other Medicaid Programs

The following are stipulations regarding coordination between the Medicaid program and the 1115 Research and Demonstration Project:

- A member whose income decreases to allowable Medicaid eligibility levels must submit a complete Medicaid application and be determined eligible through existing procedures to receive full Medicaid benefits.

- Except for the 30-day initial processing period, the enrollment fee is not refundable to members in the demonstration project who, during their 12-month benefit period, become eligible for full Medicaid benefits. However, SeniorCare will remain open to these individuals. Thus, if they subsequently become ineligible for full Medicaid benefits during the 12 months, they will automatically be able to receive SeniorCare benefits for the remainder of the 12 month period without having to pay another $30 fee.

- Members who are terminated from the SeniorCare waiver program or who fail to re-enroll will not be reviewed for eligibility for other Medicaid programs prior to termination.

G. Benefits

1. Pharmacy Benefits

Wisconsin Medicaid covers legend drugs or over-the-counter insulin prescribed by a licensed physician, dentist, podiatrist, nurse prescriber, or ophthalmologist. In addition, physicians may delegate prescription authority to a nurse practitioner or physician assistant.

Wisconsin Medicaid has an open drug formulary. This means that legend drugs or over-the-counter insulin are covered if they meet all of the following criteria:

- The drug is FDA-approved;
- The manufacturer signed a rebate agreement with the Centers for Medicare & Medicaid Services; and
- The manufacturer has reported data and prices to First DataBank.

SeniorCare statutes define prescription drugs as prescription drugs covered by Wisconsin Medicaid and for which the drug manufacturers enter into a rebate agreement with the State. However, like Wisconsin Medicaid, which covers certain over-the-counter drugs, SeniorCare extends coverage to insulin.

2. Medication Therapy Management Benefit

Effective September 1, 2012, the Department will transition its Pharmaceutical Care (PC) program that has been part of the

SeniorCare benefit to a similar but more comprehensive Medication Therapy Management (MTM) benefit, which is part of a national trend in health care.

This benefit will include traditional Pharmaceutical Care services, called Intervention-based Services, in which the pharmacist assists the patient in managing their prescription medications. The services include:

- Consultation with a member regarding a significant lack of adherence;
- Therapeutic interchange;
- Recommending a change to the member's dose based on clinical guidelines;
- Instructing the member on using a medication device (e.g. inhaler, syringe); and
- Recommendation of the addition or deletion of a medication.

There is a limit of four interventions for each kind of intervention within a year, except for interventions which result in immediate cost savings to the program; these services do not have an annual service limit.

MTM also includes Comprehensive Medication Reviews (CMRs) that allow specially trained pharmacists to review the patient's drug regimen. Members who are at a high risk of experiencing medical complications due to their drug regimen are eligible for this service. During this review, the pharmacist may:

- Obtain the necessary assessments of the member's health status.
- Formulate a medication treatment plan for the member.
- Provide information, support services and resources designed to enhance member adherence with the member's therapy regimens.
- Document the care delivered and communication of essential information to the member's primary care providers.
- Refer member to an appropriate health care provider if necessary
- Coordinate and integrate medication management services within the broader health care system.

There is a limit of one initial and three follow-up CMRs per year. Pharmacists may request an exemption from these limits.

H. Rates

Medicaid reimbursement for legend and over-the-counter drugs is the lesser of: Wholesale Acquisition Cost (WAC) plus 3.2 percent, plus a dispensing fee, for most brand drugs;

- The state maximum allowed cost (SMAC), plus a dispensing fee, for multi-sourced branded and generic drugs;
- An expanded maximum allowed cost (EMAC), plus a dispensing fee, for drugs without a SMAC or WAC rate on file;
- WAC minus 3.8%, plus a dispensing fee, for single-source generic drugs without a state MAC rate on file; or
- The usual and customary amount as billed by the pharmacy to private pay clients.

Medicaid reimbursement for medication therapy management services is:

- All Intervention-based Services, except in-home medication management and three-month supply interventions, will be reimbursed at $30 per intervention. In-home medication management and three-month supply interventions will be reimbursed at $10.
- CMRs will be reimbursed at $75 for an initial and $35 for a follow-up meeting with the pharmacist.

I. Cost Management Strategies

To further enhance the primary health care benefits and the cost-effectiveness of the SeniorCare waiver program, the Department has implemented a number of management strategies to enhance the quality of care and cost-effectiveness within the waiver program. These benefit management strategies are enumerated as follows:

1. Pharmacy Point-of-Sale (POS)

Wisconsin Medicaid implemented a pharmacy point-of-sale (POS) electronic claims management system for Medicaid fee-for-service providers statewide beginning on September 22, 1999. The POS system enables providers to submit real-time claims electronically for legend and over-the-counter drugs for immediate adjudication and eligibility verification. The real-time claims submission verifies member eligibility, including other health insurance coverage, and

monitors Medicaid drug policies. Claims are also screened against member medical and prescription history within the Medicaid system. Once these processes are complete, the provider receives an electronic response indicating payment or denial within seconds of submitting the real-time claim.

The following have occurred since the implementation of POS:

- POS permits pharmacies to submit claims and receive notification of coverage before drugs are dispensed.

- Currently, most of the state's 1,300 pharmacies are participating in real-time transactions. The average system response time is 0.4 seconds.

- Claims with "other health insurance" listed must be billed to that other insurance first.

- Claims for the same drug on the same day by one member at different pharmacies are denied because claims history is updated real-time and all Medicaid pharmacy claims are reviewed.

2. Prospective Drug Utilization Review

Prospective Drug Utilization Review (DUR) is used to enhance clinical quality and cost-effective drug use by members. At the point of sale, the Medicaid POS system screens certain drug therapy problems before the prescription is dispensed to the member. The screen provides the pharmacist with information regarding potential contraindications for the member by activating alerts that identify the following problems, presented in hierarchical order:

- Drug-drug interactions
- Drug-disease contraindications
- Therapeutic duplication
- Pregnancy alert
- Early refill
- Additive toxicity
- Drug-age precaution
- Late refill
- High Dose
- Insufficient quantity

3. Retrospective Drug Utilization Review

On a monthly basis, DHS performs retrospective DUR review. Review of drug claims against DUR Board-approved criteria generates patient profiles that are individually reviewed by pharmacists for clinical significance. Each month a software program for potential adverse drug concerns such as drug/drug interactions, overuse, drug/disease contraindications, duplicate therapy, and high dose are examined for all providers. If a potential drug problem is discovered, intervention letters are sent to all providers who ordered a drug relevant to the identified problem.

4. State Maximum Allowed Cost (SMAC) List

The federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) issues a drug list at least two times a year. This list includes drugs that are available generically from at least three companies as well as a recommended state maximum allowed cost (SMAC). In addition, states may have their own SMAC lists and set prices differently from the CMS issued prices as long as the overall amount spent for generic drugs is no more than it would have been using the CMS prices.

Wisconsin Medicaid issues its SMAC list monthly and has one of the most extensive SMAC lists in the country. SeniorCare will also use the Wisconsin Medicaid SMAC list. If a product is available generically Wisconsin Medicaid generally adds it to the state's SMAC list. Maximum prices allowed are based on prices for which drugs are readily available through wholesalers in Wisconsin.

When a drug is on the SMAC list, Wisconsin will reimburse the generic price unless the prescriber writes brand medically necessary on the prescription and obtains a prior authorization for the brand name drug. This policy encourages utilization of lower cost therapeutically equivalent generic drugs.

5. Medication Therapy Management (MTM)

Wisconsin's Medicaid's MTM program provides pharmacists with professional fees for providing intervention-based services and

Comprehensive Medication Reviews (CMRs) provided to Wisconsin Medicaid and SeniorCare members.

For intervention-based services, the professional fee reimburses pharmacists for additional actions they take beyond the required dispensing and counseling for a prescription drug.

Reimbursement requires that pharmacists meet all basic requirements of federal and state law for dispensing a drug plus completion of specified activities that result in a positive outcome both for the member and the Medicaid program. Positive outcomes include increased patient compliance and prevention of potential adverse drug reactions.

MTM also includes CMRs that allow specially trained pharmacists to review the patient's entire drug regimen. Members who are identified by the program as being at a high risk of experiencing medical complications due to their drug regimen are eligible for this service.

6. Prior Authorization

a. Under prior authorization (PA), Wisconsin Medicaid requires pharmacists to receive approval for certain drugs from the Department before reimbursement is provided. PA may be done electronically for most drugs requiring PA. Wisconsin requires drug prior authorization for the following reasons:

b. Potential drug abuse or misuse.

c. Cosmetic use only (for example, weight loss drugs not used to treat morbid obesity).

d. Encourage use of therapeutically equivalent drugs when generics are available in the same drug classification.

e. While less than 1 percent of covered drugs require it, PA has been shown to slow the rate of increase in drug expenditures without impeding access to necessary and appropriate drugs. Through PA, categories of drugs are reviewed for similar products, some of which are available generically and some only brand, When this situation exists, Wisconsin requires PA for the brand drugs. However, before any changes are made to the PA requirements, drug manufacturers are notified and a review process is followed. This process assures high quality to our members and cost-effectiveness for the program.

7. Diagnosis Restriction and Excluded Drugs

Under Wisconsin Medicaid, a diagnosis restriction applies if the prescribed use is not for a medically accepted indication, In addition, certain drugs may be excluded from coverage and are on the Medicaid Negative Formulary drug list, and drugs that are experimental or have no medically accepted indications.

8. Preferred Drug List

Effective October 1, 2004, the Department implemented a preferred drug list (PDL) and Supplemental Rebate program for Medicaid, BadgerCare, BadgerCare Plus and SeniorCare.

Based on the therapeutic significance and cost effectiveness of a drug, supplemental rebates with manufacturers are negotiated and PDL recommendations are made to the Wisconsin Medicaid Prior Authorization (PA) Advisory Committee, which is composed of physicians, pharmacists, advocates, and consumers from the state of Wisconsin.

To establish drugs to be included on the PDL, the PA Advisory Committee reviews research and clinical information prepared by clinical pharmacists. Research is based on peer-reviewed medical literature and current studies and trials.

Non-preferred drugs require PA. Preferred drugs on the PDL do not require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs.

9. Drug Authorization and Policy Override (DAPO) Center
Providers may contact the DAPO Center in order to request certain prior authorizations or to request an override of current policy on a case-by-case basis. Examples of policies that may be overridden include 100-day supply, early refill, quantity limits and limits on MTM services and opioid prescriptions.

III. DEMONSTRATION PROJECT RENEWAL PROGRAM ADMINISTRATION

A. Administering Agency

The State of Wisconsin administers the SeniorCare Pharmacy Plus waiver program through the Wisconsin Department of Health Services. Portions of the program may

be administered by private entities under contract with the State, such as claims processing, communications, customer service, application processing, and other related services.

B. Financing

Prescription drug services under the 1115 Research and Demonstration Project are funded jointly through State general purpose revenue (GPR) funds and matching federal funds. Additional program revenue for the 1115 Research and Demonstration Project comes from the previously mentioned, annual enrollment fees, copayments, and monies from the drug rebate program. Wisconsin currently has drug rebate agreements with all pharmaceutical companies participating in the Medicaid rebate program pursuant to Section 1927 of the Social Security Act.

C. Provider Network

SeniorCare provides access to a robust network of pharmacies. There are currently 1,300 pharmacies in-state and another 100 out-of-state that are Medicaid certified providers. SeniorCare administrative code requires Medicaid certified pharmacies to serve SeniorCare members.

D. Implementation Schedule

SeniorCare is currently a successfully implemented waiver program, determining eligibility and providing outpatient drug benefits to an average of about 58,000 seniors per month. The current three-year waiver renewal demonstration program is set to expire December 31, 2012. SeniorCare is poised to continue delivering this benefit beginning January 1, 2012 through December 31, 2015, with this renewal.

E. Early Termination of the Waiver Program

Wisconsin reserves the right to end this 1115 Demonstration Project should actual experience show that it is not cost-effective or cost-neutral.

IV. WAIVERS REQUESTED

This waiver renewal requires continued waivers from Title XIX of the Social Security Act. Section 1115(a)(1) of the Social Security Act permits the Secretary of the Department of Health and Human Services (the Secretary) to waive compliance with any of the requirements of Section 1902 of the Social Security Act, which specify State Medicaid Plan requirements, to the extent and for the period necessary to carry out the demonstration project. Section 1115(a)(2) permits Wisconsin to regard as expenditures under the State plan costs of the demonstration project, which would not otherwise receive a federal match under section 1903

of the Social Security Act. These provisions allow the Secretary to waive existing program restrictions and provide expanded eligibility and/or services to members not otherwise covered by Medicaid. Wisconsin requests that the Secretary waive all relevant Medicaid laws and regulations which would allow Wisconsin to receive federal matching funds, including the following Title XIX provisions:

A. **Eligibility.** Wisconsin requests the Secretary to waive Sections 1902(a)(10)(A) and 1902(a)(17) of the Social Security Act. These sections prohibit Federal Financial Participation to states that implement eligibility standards in excess of the stated maximums and in manners not consistent with the standards prescribed by the Secretary. These sections also specify that methodologies must be applied in the same manner to all individuals in the same eligibility group. Wisconsin seeks a waiver to:

Expand eligibility for pharmaceuticals to waiver demonstration members with incomes at or below 200% FPL;

- Apply different methodologies as described above to waiver demonstration members than would be applied to blind and disabled persons under age 65 or to regular Medicaid recipients.

- Apply different standards than those prescribed by the Secretary related to eligibility determination. Eligibility will be re-determined and income will be reassessed for waiver members once every 12 months.

B. **Comparability**. Wisconsin requests the Secretary to waive Section 1902(a)(10)(B) of the Social Security Act. These sections require the amount, duration, and scope of services be equally available to all members within an eligibility category and be equally available to categorically eligible and medically needy members. Wisconsin seeks a waiver of these provisions to offer a comprehensive drug benefit to the expanded population.

C. **Cost Sharing.** Wisconsin requests the Secretary to waive Section 1902(a)(14) of the Social Security Act relating to enrollment fees, copayments and other cost sharing. Wisconsin seeks a waiver to:

- Collect an annual enrollment fee of $30 per person. This cost-sharing revenue will be used as state matching funds to federal financial participation for the administrative costs of the program;
- Establish that certain members in the waiver demonstration would pay the first $500 of prescription drug costs prior to receiving the benefit of obtaining prescription drugs at the copayment levels; and
- Establish copayment amounts higher than those used for the general Medicaid population.

D. Ex Parte Eligibility Redetermination. Wisconsin requests the Secretary to waive section 1902(a)(19) of the Social Security Act and federal regulations at 42 CFR 435.902 and 42 CFR 435.916 related to ex parte eligibility redeterminations. Wisconsin seeks a waiver to:

- Require that a separate waiver demonstration application be filed by an applicant who is no longer eligible for regular Medicaid prior to being determined eligible for the waiver demonstration program; and
- Require a waiver demonstration member to file a separate Medicaid application if they are interested in receiving benefits under any other Medicaid subprogram.

E. Program Integrity. Wisconsin requests the Secretary to waive Section 1902(a)(46) of the Social Security Act and federal regulations at 42 CFR 435.920 and 42 CFR 435.940 through 435.965 related to verification of applicant and recipient income and eligibility information. It is anticipated that certain income sources may have limited applicability for the waiver demonstration population, which generally is perceived as having fixed income. Further, because income is tested prospectively on an annual basis under the waiver demonstration and because data from other sources represents a prior time period, some items may not be relevant in determining eligibility for SeniorCare. In exploring the most efficient and effective methods for ensuring program integrity, Wisconsin intends to do the following:

- Validate social security numbers at the time of application through the Social Security Administration numident process. If it is found that a person does not have a social security number, the person will be assisted in obtaining a social security number. If it is found that there is a mismatch between the SSA information and the social security number provided by the client, the mismatch will be resolved as needed;
- Automatically test Social Security Administration benefits against tolerance levels established by the Department at application and-review. Those case situations that exceed tolerance levels will be verified and discrepancies will be resolved. In addition, periodic random samples of all cases will be conducted to ensure that SeniorCare eligibility is based upon the correct social security benefit information regardless of whether there is a discrepancy that exceeds the threshold.
- In addition, social security administration benefits, earnings from wages, earnings from self-employment, other unearned income and unemployment compensation will be verified after application to ensure program integrity. In particular, a random sample of all recipients will be taken. If a failure to report

information results in an incorrect eligibility determination, program costs would be recovered.

F. **Retrospective Benefits.** Wisconsin requests the Secretary to waive Section 1902(a)(34) of the Social Security Act and 42 CFR 435.914 that require a state to retrospectively provide medical assistance for-three months prior to the date of application in certain circumstances. Wisconsin requests a waiver to establish the effective date for demonstration members as the date of enrollment as determined in accordance with Section III(C), above.

G. **Enrollment.** Wisconsin requests the Secretary to waive Section 1902(a)(10) of the Social Security Act related to entitlement of benefits. Wisconsin statutes require that, during any period in which funding for benefit payments under the program is completely expended, all of the following shall apply:

- The Department may not pay pharmacies or pharmacists for prescription drugs or over-the-counter insulin sold to program members;
- Pharmacies and pharmacists will not be required to sell drugs to eligible program members at the program payment rate;
- Eligible program members will not be entitled to obtain prescription drugs or over-the-counter insulin for the copayment amounts or at the program payment rate;
- The Department may not collect rebates from manufacturers for prescription drugs purchased by program members;
- The Department may not pay pharmacies and pharmacists for medication therapy management services received by program members; and
- The Department is required to continue to accept applications and determine eligibility for the program, and must indicate to applicants that the eligibility of program members to purchase prescription drugs under the requirements of program is conditioned on the availability of funding.

H. **Hearings and Appeals.** Wisconsin requests the Secretary to waive Section 1902(a)(3) of the Social Security Act and federal regulations at 42 CFR 431.211 and 42 CFR 431.213 relating to required notification by the Department for an adverse action in cases where the recipient has clearly indicated that he or she no longer wishes to receive services. These sections specify that the 10-day required notification prior to an adverse action does not apply in cases where the recipient has clearly indicated in writing that he or she no longer wishes to receive services. Under the waiver demonstration, an exception to the 10-day required notification would apply in eases where the recipient has clearly notified the Department either orally or in writing that he or she no longer wishes to receive services.

In addition, Wisconsin requests that, under the authority of Section 1115(a)(2), expenditures for the items identified below (which are not otherwise included as expenditures under Section 1903) be regarded as expenditures under Wisconsin's Medicaid State Plan:

- Expenditures to provide and receive comprehensive pharmacy benefits to seniors age 65 and older whose income is at or below 200 percent of the FPL.
- Administrative expenditures for demonstration members includes, but is not limited to, collecting program members' fees, enrolling pharmacies, producing and distributing enrollment cards to program members, responding to client inquires, developing and processing applications, determining eligibility, collecting third-party insurance information and - evaluation and monitoring of this demonstration waiver.

  Wisconsin requests the right to request other waivers to implement the proposed pharmacy program, if necessary.

V. BUDGET AND COST-EFFECTIVENESS ANALYSIS

As reported to CMS, the SeniorCare waiver achieved budget neutrality throughout the original waiver period and in all waiver extension periods.

Under this proposed demonstration project renewal, the Department projects that it will continue to reduce overall Medicaid expenditures for the aged population, 65 and older, with continuation of the SeniorCare program by providing primary care benefits for pharmacy with accompanying MTM services under the waiver renewal proposal. As in the original waiver period, budget neutrality will continue to be achieved by reducing the rate of increase in the use of non-pharmacy related Medicaid services provided to this population including, hospital, nursing facility and other non-pharmacy medical services. The savings realized by reducing the rate of increase in non-pharmacy Medicaid services for this population will offset the costs of continuing the SeniorCare pharmacy benefit.

This cost-effectiveness analysis is conducted by projecting Medicaid expenditures for the aged population that would have occurred without the SeniorCare waiver and comparing that to projected Medicaid aged population expenditures with the continued operation of the pharmacy waiver program and the cost of the waiver program under the proposed renewal. Under both tests, the availability and impact of Medicare Part D is factored into the tables and with the narrative description below, present the data and assumptions used to calculate budget neutrality for the proposed three year waiver renewal period (Budget Neutrality (Attachment A).

Table 1A establishes the pre-waiver historical trend (SFY 1998-2002) of Medicaid expenditures and enrollment. The data in this table are the same data used in the original

waiver submission. This table also projects "without waiver" Medicaid expenditures for SFYs 2003-2009. The waiver trends for these time periods were developed by applying rates approved by CMS in the original 2002 waiver submission.

Table 1B projects "without waiver" Medicaid expenditures and enrollment for the current waiver period of CY 2010 to CY 2012 as well as for the new renewal period of CY 2013 to CY 2015. This table makes adjustments to the "without waiver" data submitted to CMS in the last waiver renewal application. The reason this was done was that in order to project CY 2013 through CY 2015 accurately, we needed "base" numbers for CY 2010 through CY 2012 that were more consistent with actual changes in the Medicaid program with the waiver in place.

Variables related to the implementation of Medicare Part D were taken into consideration, including reducing pharmacy costs to exclude dual eligible drug expenditures and reducing the member month growth rate to reflect diversion from Medicaid due to Part D.

Table 2A presents Medicaid expenditure trends with the SeniorCare waiver in place from SFY 2002 to SFY 2009. This table tracks trends in annual expenditures, eligible member months and cost per eligible.

Table 2B shows the "with waiver" Medicaid costs in the current waiver period of CY 2010 to CY 2012 and projections for the waiver renewal period of CY 2013 to CY 2015.

Table 3A shows historical SeniorCare expenditure data for the SFY 2003 to SFY 2008. This table tracks trends in annual expenditures, manufacturer rebates, eligible member months and cost per eligible.

Table 3B shows SeniorCare expenditure data for CY 2009 to CY 2012 and the projected expenditures for the renewal period CY 2013 to CY 2015.

Table 4 is the summary of the SeniorCare budget neutrality calculation for the current (CY 2010 to CY 2012) and proposed (CY 2013 to CY 2015) waiver renewal period. It compares the total projected Medicaid expenditures with the waiver plus SeniorCare waiver expenditures to projected Medicaid expenditures had the waiver never been implemented. The "without waiver Medicaid expenditures" projected in this table are based on the new expenditures estimates from Table 1B.

As shown in Table 4, it is projected that total Medicaid aged and SeniorCare costs with the continued renewal of the SeniorCare waiver will be less than total Medicaid aged costs without the waiver renewal. This expenditure offset is accomplished by reducing the rate of growth in the number of individuals who otherwise would have become eligible during the

waiver period as a result of the improved health of this population, and by a reduction in the number of individuals in this population who spend down to Medicaid eligibility.

In addition, the federal government will benefit from the proposed renewal of SeniorCare through a reduction in Medicare expenditures due to lower utilization of acute care services for this population group.

Our analysis shows that not only will continuing the SeniorCare waiver be budget neutral, it will produce savings over what would have been spent without the waiver.

MTM Costs were added to Tables 1B, 2B and 3B.

With MTM replacing the pharmaceutical care services, whose costs were previously factored into the tables, we now calculate MTM costs. We estimated costs for the two different types of intervention—Intervention-based Services and Comprehensive Medication Reviews (CMRs).

Intervention-based Service costs were estimated using the following assumptions:

- Each member is potentially eligible to receive the service. Number of members were projected in Table 1B, 2B and 3B for CY 2013, CY 2014 and CY 2015.
- CY 2011 pharmaceutical care claims experience was used to estimate claims experience for intervention-based services for CYs 2013-2105. Estimated number of annual claims for each year was multiplied by the cost per claim to arrive at an estimated annual cost for intervention-based services.

Comprehensive Medication Review costs were estimated in 2 ways. To estimate the "without waiver" scenario costs:

- Use the number of members projected in Table 1B.
- Apply a percent to that number to determine who would likely be eligible to receive CMR services.
- Estimate that 75% of those people use a WPQC-certified pharmacy.
- Estimate that 50% of those people will accept CMR services and will receive an initial CMR service at $75 per service.
    - Estimate that 50% of those people will get a 1st follow-up CMR service at $35 per service.
    - Estimate that 25% of those people will get a 2nd follow-up CMR service at $35 per service.
    - Estimate that 12.5% of those people will get a 3rd follow-up CMR service at $35 per service.

To estimate "with waiver" and "SeniorCare" scenario costs:

- Using claims experience, estimate the number of Medicaid and SeniorCare members eligible for a CMR.
- Apply the Medicaid or SeniorCare enrollment trend to each initial eligible population estimate to derive number of members eligible for CMR services each year.
- Estimate that 75% of those people use a WPQC-certified pharmacy.
- Estimate the 50% of those people will accept CMR services and will receive an initial CMR service at $75 per service.
    - Estimate that 50% of those people will get a 1st follow-up CMR service at $35 per service.
    - Estimate that 25% of those people will get a 2nd follow-up CMR service at $35 per service.
    - Estimate that 12.5% of those people will get a 3rd follow-up CMR service at $35 per service.

VI. PUBLIC INVOLVEMENT

The State of Wisconsin has a tradition of open government and extensive public involvement in the design, implementation and administration of major programs.

As part of this effort, SeniorCare provides a website for the public to access different kinds of information about the program at www.dhs.wisconsin.gov/seniorcare. The waiver renewal was added to this website in order to allow opportunities for public comment. Waiver renewal information can be found at: www.dhs.wisconsin.gov/seniorcare/input/index.htm.

This website provides a comprehensive description of the SeniorCare program, including program goals and objectives, eligibility and benefits. The initial draft waiver application includes historical and expected enrollment and expenditures, evaluation parameters, specific waivers requested, a minimum 30-day advance notice of public meeting dates and times of public meetings and information on providing comments.

Forums for public comment included the following:

- SeniorCare Advisory Committee;
- Coordination with Native Americans;

- Public Hearings;
- SeniorCare Waiver Renewal Website, including online comment form; and
- Addresses and phone numbers published for public to comment.

A. SeniorCare Advisory Committee

To ensure ongoing communication and coordination with stakeholders, the Department has established a SeniorCare Advisory Committee. The Advisory Committee meets in open forums to advise the Department on important SeniorCare matters. The SeniorCare Advisory Committee met on May 18, 2012 and July 16, 2012.

In 2012, the SeniorCare Advisory Committee included representatives from:

- Senior advocacy groups (AARP)
- Benefit Specialists (Wisconsin Area Agencies on Aging, and the Wisconsin Board on Aging and Long Term. Care);
- Providers (pharmacists and physicians practicing in Wisconsin);
- Community partners (county and tribal community care representatives, The Pharmacy Society of Wisconsin (PSW) and PhRMA); and
- State and federal agency representatives (the Wisconsin Department of Health Services and the Centers for Medicare and Medicaid Services).

B. Coordination with Native Americans

Wisconsin has a long-standing working relationship with tribal health directors in the State. The State has worked closely with tribal health directors on Medicaid HMO implementation, on BadgerCare Plus, and on issues to meet specific tribal health care needs. For instance, a special disenrollment procedure was developed for tribal members that involved close coordination with Indian Health Service Clinics, tribal members, and the Medicaid HMO enrollment broker. A special payment system was developed so that non- HMO affiliated Indian Health Clinics could still be reimbursed by Medicaid fee-for-service funds for services provided to tribal members enrolled in HMOs, so that Indian Health Service funds would not be jeopardized by the expansion of the HMO program.

The Department of Health Services continues to hold regular meetings with tribal members to discuss health care related issues, including SeniorCare.

The SeniorCare Waiver renewal request was discussed at the June 27, 2012 tribal consultation meeting. A letter to Tribal Leaders and Tribal Health Directors was sent on June 29, 2012 offering different options for submitting comments regarding the initial draft waiver application. A subsequent email was sent on August 22, 2012 with an updated draft waiver application for a final opportunity to comment.

C. Public Notices

As part of the waiver renewal request process, Wisconsin held six public meetings. Notices of each meeting were published and press releases were issued well in advance of the dates.

Two of the hearing notices were published in the State's official administrative record, the Wisconsin Administrative Register, Mid-June 2012 edition, volume 678a and one was published in the same edition, volume 678b. These notices included a comprehensive description of the SeniorCare program, including program goals and objectives; eligibility and benefits; historical and expected enrollment and expenditures; evaluation parameters; and specific waivers requested. This information was also posted on the Department's website.

The public was able to call in with their comments at two of the meetings. There were approximately 20 people in attendance at each meeting. Two of the hearings were led by the Medicaid Director and one was led by the Deputy Secretary.

The following public meetings were held:
SeniorCare Advisory Committee Meeting
Friday, May 18, 2002
9:00 am to 11:00 am
Room 751
Department of Health Services
1 West Wilson St
Madison, WI 53704

Tribal Health Directors Meeting
Wednesday, June 27, 2012
10:00 am to 3:00 pm
Howard Johnson Inn and Conference Center
2101 North Mountain Road
Wausau, WI 54401

SeniorCare Public Hearing
Thursday, June 28, 2012
10:00 am to 12:00 noon
Portage County Annex
1462 Strongs Avenue
Stevens Point, WI 54481

SeniorCare Public Hearing
Friday, June 29, 2012
10:00 am to 12:00 noon
State Office Building
141 NW Barstow Street, Room 151
Waukesha, WI 53188

SeniorCare Public Hearing
Friday, July 13, 2012
10:00 am to 12:00 noon
County Board Room
St. Croix County Government Center
1101 Carmichael Center
Hudson, WI 54016

SeniorCare Advisory Committee Meeting
Monday, July 16, 2012
9:00 am to 11:00 am
Room 751
Department of Health Services
1 West Wilson St
Madison, WI 53704

D. SeniorCare Waiver Renewal Website

Various types of written material have been created to inform the public on an ongoing basis of the State's progress and goals in implementing and operating SeniorCare, such as a draft of the application, fact sheets and brochures, hearing notices, presentations and media announcements. These materials are available on the Department's SeniorCare web site, which is: www.dhs.wisconsin.gov/seniorcare.

On this website, there was also a form to use for comment submissions through an online survey tool. The comment period closed on Monday, July 16, 2012. Meeting notices and our website also gave an address to which comments could be mailed.

E. Email List

On the same website as is referenced above, there is a tool members of the public could use to sign up for email updates on the SeniorCare renewal.

F. Post-Extension

The SeniorCare Advisory Committee will continue to meet on a quarterly basis. The Department's public website will also be continuously updated and available.

VII. PUBLIC COMMENTS

The Department received approximately 300 comments via telephone, email, web form, public hearings and mail (see Attachment B). Comments came from pharmacists, pharmacy and medical students, advocates, veteran's services officer, prospective and current members and family and elected officials.

A. Overall Comments

The main themes of the comments were:

- Keep the SeniorCare program as is;
- SeniorCare is a life-sustaining program for many members; and
- Consider adding Medication Therapy Management as a means to save money by keeping seniors healthier.

B. Web Form Comments

To summarize, of the 158 comments received via the web form:

- 150 were in support of renewing the SeniorCare waiver;
- One person felt SC wasn't needed because there is Medicare Part D; and
- 93 comments recommended the Wisconsin Pharmacy Quality Collaborative (WPQC), with 4 comments that recommend medication therapy management without specifying WPQC.

VIII. CMS OVERSIGHT OF WAIVER PROGRAM QUALITY

CMS oversight of the Waiver Program is an on-going activity that consists of different kinds of interaction with the states. On-going dialogue is not new. Regional Office staff has always communicated with states in many different ways. These interactions with states throughout the life of a waiver are an important aspect of CMS over-sight activity.

Information accumulated though on-going dialogue with states adds to the body of information formally obtained through the quarterly and annual reports, state responses to CMS requests for information, complaints to CMS and state follow-up, CMS technical assistance and training, etc.

When gathered continuously over the three to five year cycle, the observations and body of information will serve as the basis for providing the state with a CMS report on the state's implementation of the waiver prior to the state's development of a renewal application. CMS on-going dialogue takes many forms, including:

- On-site direct observation of state activities;
- Direct communication with members, families and advocates;
- Provision of technical assistance;
- Review of written documents; and
- Other forms of dialogue.

On-site direct observation of state activities provides concrete evidence that the state is carrying out the program, including quality management activities, as described in its approved waiver. Examples include:

- Participating in state over sight activities (i.e. monitoring visits conducted by the operating and/or Medicaid agency of sub-state agencies and/or service providers); talking with state staff who carry out this activity;
- Observing delegated program administration functions, i.e. talking with sub-state agency managers about service delivery and their understanding of requirements and the state's oversight of their functions; and

- Observing services being delivered and talking with providers about service delivery and their understanding of requirements.

Direct communication with members, families and advocates provides an opportunity to hear directly about the experiences of individuals in the system, to learn about the program, to affirm CMS's oversight role and to provide information and respond to questions about the federal program.

These interactions may occur:

- On a one-to-one basis during program visits;
- In response to complaints from members, families, providers and other stakeholders; and/or
- CMS staff may request of states the opportunity to participate in any standing meetings or events that provide an opportunity to meet with groups of members, families and advocates.

Through the provision of technical assistance, relationships between CMS and state agency staff develop that facilitate information sharing. Technical assistance to the states provides valuable assistance in understanding and meeting CMS expectations and in improving quality. Examples include:

- Phone contact;
- State agency staff visit CMS offices; and
- CMS staff visit to the State agency.

Review of written documents**,** including:

- Reports filed by the state as required follow up to an inquiry, a review or investigation;
- Evaluation reports required by a renewal application approval; and
- Standard quality management reports submitted by the state on a voluntary basis to inform the Regional Office.

Other/General Dialogue

- Attending and presenting at state sponsored conferences or meetings including the SeniorCare Advisory Committee;
- Hosting education days (meetings or calls) for sharing information among states and Regional Office;
- Monthly meetings /phone calls with State Medicaid Directors to discuss developments in the federal program and state issues; and

- It is essential that CMS staff document the on-going dialogue to record and preserve the interactions between CMS and State staff and the outcome/decisions made as a result of the dialogue.

IX. EVALUATION ACTIVITIES AND FINDINGS

A. Quality Measures

The Department has contracted with Brandeis University researchers to complete a qualitative analysis of the SeniorCare waiver program by early 2013, which will be shared with CMS once complete. Shown below are the indicators of the quality and accessibility of the waiver program that the Department has observed through program monitoring activities.

1. Overall Support for SeniorCare

One needs only to look at the overwhelming outpouring of support for the program to know that it is perceived by the public as being a high-quality program that provides essential benefits to Wisconsin seniors.

2. Renewal Rates High

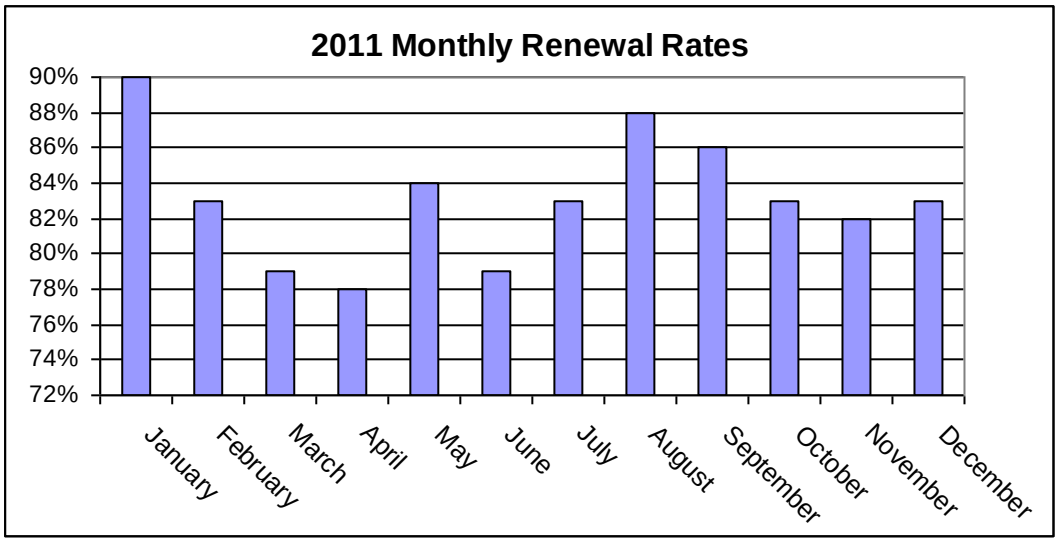
Another measure of program quality is the rate at which people whose benefit year expires renew for another 12-month benefit period.

SeniorCare waiver and non-waiver program renewal rates are high and customer problems and appeals are low. On average 84% of people who received a renewal notice returned their renewal in order to extend their benefit period for another 12 months.

CY 2011 SeniorCare Waiver Applications and Renewals

Month	New Applications	Renewals Due	Renewals Received	Renewal Rate
January	1,030	5,075	4,547	90%
February	870	4,540	3,757	83%
March	913	5,144	4,084	79%
April	772	4,981	3,876	78%
May	858	5,565	4,692	84%
June	746	3,498	2,774	79%
July	779	3025	2,517	83%
August	940	14,126	12,416	88%
September	959	6,005	5,143	86%
October	1,300	5,482	4,532	83%
November	1,928	7,519	6,157	82%
December	2,120	11,638	9,674	83%
Total	**13,215**	**76,598**	**64,169**	**84%**

Another way to look at this is that of the 69,709 members eligible for the SeniorCare waiver program during CY 2010, 59,827 (86%) applied for renewal and were found to be eligible in 2011. The rest either didn't apply or applied and were found ineligible for the program.

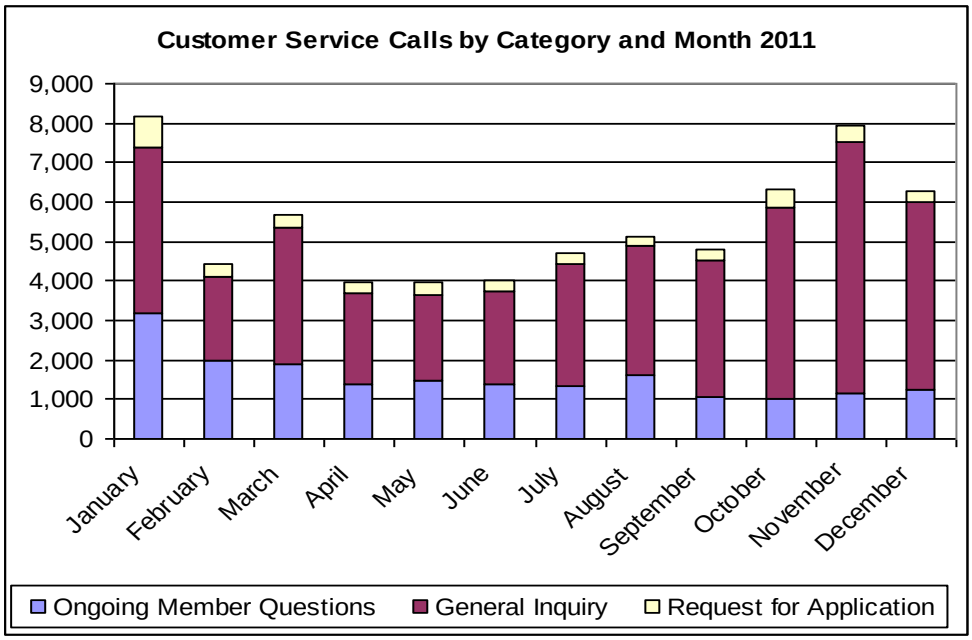


3. Number of Calls from Members with Questions Low

Not only are renewal rates high, but calls from members with questions are low. The SeniorCare Customer Service Hotline (hotline) is staffed with six full-time equivalent (FTE) correspondents. The majority of calls received by the hotline can be classified into three categories:

a. Non-members who have general inquiries about the program;
b. Members who want to report a change or have specific questions about benefits; and
c. Non-members requests for applications.

This chart shows that for all months, general inquiries are most frequent. Calls from members who have questions about their benefits are of medium frequency in relation to other calls. Since the program is deliberately kept simple so that benefits are easy to understand and use, it makes sense that there would not be a lot of calls with questions.



4. Drug Utilization Review (DUR) Improves Quality

Earlier in this application is a discussion of the use of the DUR as a cost-saving strategy. Not only does this activity help control costs, but it also contributes to the quality of care delivered under the program.

Prospective Drug Utilization Review (DUR) occurs at the point of sale (POS). The Medicaid POS system screens certain drug therapy problems before the prescription is dispensed to the member. The screen provides the pharmacist with information regarding potential contra-indications by activating alerts that identify problems.

On a monthly basis, the Department performs retrospective DUR review. The review of drug claims against DUR Board-approved criteria generates patient profiles that are individually reviewed for clinical significance. If a potential drug problem is discovered, intervention letters are sent to all providers who ordered a drug relevant to the identified problem.

5. Advisory Committees Help Ensure Quality

As was already mentioned, the SeniorCare program has its own advisory committee. In addition to that committee, the Department has other committees that advise on topics such as mental health and drugs to include on the Preferred Drug List. The participation of these groups is essential to improving and maintaining the high quality of care the program has always provided.

B. Quantitative Measures

1. External Evaluation

An evaluation of the SeniorCare waiver program was completed by Brandeis University in 2005. Findings were as follows:

a. SeniorCare reduced skimping on/going without medication

A member survey found that SeniorCare had a dramatic reduction in self-reported going without necessities and skipping prescribed drugs for financial reasons (what Brandeis called skimping), particularly among the most vulnerable beneficiaries.

b. SeniorCare reduced Medicaid expenditures and nursing home entry

The Medicaid program savings were more than sufficient to pay for the SeniorCare waiver program. Among the financially most vulnerable populations, SeniorCare enrollment was associated with

reductions in Medicaid expenditures and nursing home entry of about 50% compared to the control state, which was Ohio. The rate at which SeniorCare members became eligible for full Medicaid benefits in the first year was 11% compared to matched Ohio control entry rate of 22%. The rate of nursing home entry of SeniorCare members was 2.2% compared to 4.5% for the matched Ohio controls.

c. Medicaid spending for former members of SeniorCare was reduced. For former SeniorCare members, Medicaid spending per entrant was significantly lower compared to matched Ohio controls.

d. Medicare costs and utilization reduced after SeniorCare. Models that examined the difference in Medicare costs and inpatient utilization before and after the 2003 implementation of SeniorCare found evidence of positive, but modest, decreases in Medicare costs and inpatient utilization (compared to Ohio).

2. Current External Evaluation

The Department contracted with Brandeis University. Dr. Donald Shepard and Dr. Cindy Thomas completed an evaluation of the most recent SeniorCare waiver period of CY 2010, CY 2011 and CY 2012. The researchers were given data they could use to evaluate the program. Their analysis of this data showed the following:

a. SeniorCare remains a very popular program in Wisconsin.
b. The waiver program has a relatively stable enrollment of between 71,000-75,000 each year between 2008 and 2011, with a consistent distribution by income and gender over these years (Figures 1, 1a-1b).
c. SeniorCare is increasingly being used as a wrap-around for Part D (Figure 2).
d. Most members have been in the program for three or more years, and about 70-75 percent re-enroll from one year to the next. This is a favorable retention rate.
e. Between 2002 and 2005, the proportion of Wisconsin seniors without drug coverage (prior to Medicare Part D) decreased by 37% for individuals less than 100% of poverty, and 25% for those between 100 and 200% of poverty (Table 5).

f. Program spending in total and per member has decreased in the years 2008 through 2012, including lower member out of pocket costs.
g. Finally, SeniorCare appears to be an efficient program. According to estimates provided by the program, administrative costs are less than three percent of program costs, a favorable comparison to either Medicare or private health insurance (Table 10).

The full report is available in Attachment C.

As previously mentioned, the researchers will also complete a qualitative analysis of the program, which will be shared with CMS in mid-2013.